

“The Plight of the Uninsured”

A community forum and health fair

Tabernacle Presbyterian Church
Indianapolis, IN
Wednesday, May 3, 2006
5:30 – 7:30 p.m.

Approximately 100 people attended the Indianapolis Forum. The speech summaries, questions, and comments below are meant to capture the general ideas or messages of the speakers and audience. The comments and responses are not verbatim.

KEYNOTE SPEECH

Secretary Mitch Roob, Indiana Family and Social Services Administration

Sec. Roob presented for 20 minutes, highlighting the following:

- Public Forums across the state
- Federal flexibility through the Deficit Reduction Act (DRA)
- Current and future financing mechanisms
- Current and future delivery mechanisms
- Is the cure worse than the disease?

PANELIST DISCUSSION

Matt Gutwein, CEO of Health and Hospital Corporation (HHC)

HHC operates Wishard Hospital, Marion County’s public hospital.

I will state my position up front. I am eager to support these proposals to do something about the uninsured. I’m behind Secretary Roob.

Let me offer broader context on this issue that the Governor, Sec. Roob, Sen. Pat Miller and many others have asked to be publicly discussed. The uninsured are a portion of that problem. Yet, the broader problem starts with this fact: we have the most expensive health care system in the world. We spend \$1.9 trillion annually. Second, we have a system that delivers mediocre quality in terms of health care. The World Health Organization (WHO) ranked us 37th. The U.S. is 58th in immunizations of children. The U.S. is ranked 75th in death rates for children. Diabetes, heart disease, obesity... we are at the very bottom of industrialized nation.

And we have this army of uninsured – 46 million in this country. In Indiana, our rate of uninsured is growing twice the nation’s rate. We also have almost unspeakable racial disparities. Minorities perform more poorly than whites in most health outcomes. As everyone has gotten a little healthier, the gap continues to widen.

On top of that, we have a system in which more of our employers, who fund most of the health insurance, are unable to afford it. Health insurance has become a tax on our employers. Virtually every employer has this extra tax where Canadians, Koreans, Chinese, etc, do not. Our employers have difficulty competing in the global market; they are non competitive in the cost of health care. We are seeing this in automobile, air, steel, and other industries. They are going out of business because they have offered nice health care benefits. Their greatest sin is their longevity. They are non competitive because of the extreme cost of health care benefits.

Only 60% of the small business employers in this country offer health insurance. In small businesses than employee 11 or less, it's 30%. They are not in a position to offer health care. This creates a bad problem, especially when compared to the rest of the world.

Here are some comparisons: We are more expensive – 75% more than Canadians, 50% more than English, French. And they have fewer health disparities, spend less, and are healthier. No other major industrialized country has the uninsured, as we do. Because of that fact, there's not a double tax on employers to pay for the uninsured too.

It's a problem with many losers. We all pay for it. The disadvantage is that Sec. Roob has it to deal with this on a statewide level. To quote him, there's a crazy quilt of financing; there are enormous constraints on how to solve the problem. But, in the end, if it is solved in the best possible way in Indiana, it will still be an imperfect way. I believe, ultimately, that we will never create the kind of health care system we need until we have a national solution. That national solution will be one that puts us in line with the rest of the world. Then, the U.S. won't be the outlier.

How is the rest of the world having more thriving businesses, better health outcomes, fewer racial disparities, and higher consumer satisfaction than in the U.S.? The U.S. system is dead last in consumer satisfaction. The number one thing that the other countries do is this: they all base the financing mechanism on a single risk pool. All insurance is a risk pool. There are other examples – such as the Raphael Health Center across the street. We have thousands of risk pools. The financing mechanism is through the one risk pool. Why has that produced good results? It's vastly cheaper to operate. It's true because of the administrative burden – the average insurance company has an administrative cost of 25 – 30 cents on the dollar. That's in comparison to the Medicare system, which has an administrative cost of 3 cents on the dollar. In other words, 97 cents of every dollar pays for health care. Medicaid has an administrative rate of 8 cents on the dollar. The worldwide average of the industrialized country is 7 – 9 cents per every dollar. So, it costs less. A larger risk pool can accommodate greater economic stability.

One final thing... why do we have this system that costs so much? The very fact that we permit 46 million uninsured grossly drives up the cost of our system. They cost more to serve – they delay care, they don't get primary care, they cannot afford the medicines,

etc. But others protest that offering the uninsured insurance will be wildly expensive. But we already pay for it. We have universal care. Everyone pays.

Billie Dragoo, Repucare, Owner

Repucare is one of the 25th largest women-owned businesses in Central Indiana and supplies therapists to hospitals and clinics.

I started Repucare out of my house in 1995; we have 45 employees. We provide health care coverage to these people. Up until last year, we paid 100%. The purpose is to retain these employees. Now, they pay \$40 per month, which helps the company share the costs. We have to do this to retain our employees to be on a level playing field with other providers around the state.

I advocate on women's businesses. Health care has been a critical issue since 1986. The NFIB deemed it critical. It is not sustainable. This threatens the life of small business. I appreciate your help as we try to craft a system.

Rev. Dr. Angelique-Smith, Church Federation of Greater Indianapolis, Executive Director

We are founded in 1912, and you are in the home of one of our charter churches. Perhaps you have heard these holy words. "I was hungry and you gave me food. I was sick and you visited me." Or, "the blessed are the merciful for they shall obtain mercy." What about "Thou shall love the neighbor as thy self"?

These words were all in the Book of Luke in the Christian bible. As many of you know, Luke was a physician. He wrote Acts and Luke. You will find Jesus the Savior, for those who are Christian, leading acts of healing. Some are so persuaded that they feel this healing ministry is the whole reason they have converted to Christianity. Jesus was about healing.

This is an inter-faith and secular issue. Why do communities proclaim the call to care? This is a national call to come together. 1. It's a holy call; it's a commission. Faith communities have a long tradition of caring for the sick and needy. 2. They pray for the sick. They comfort. They have founded hospitals. 3. They have led the way in seeking just and compassionate public policies.

Jewish teachings demonstrate that if you saved one's life, it's as if you've saved the world. Muslim teachings direct to help one another in righteous and piety. I've already reviewed many of the Christian teachings.

They hold central a conviction that life is a gift of God; we are called to take care of one another. The faith leaders are coming together in a convention. (List 10 commissions or entities.) There's not a faith community that doesn't have someone knocking on their door at all hours of the day that is looking for care. "I have no where to go." There are

many parishioners that may not have much themselves, but take people in when nobody else will. Take people in where they don't have to fight the red tape and bureaucracy. This issue is very real. Affirm and confirm your beliefs and values and to help the uninsured.

One problem topples another. If you have sick kids, you may have to stay home from work. We want to wrestle with what it will take for Indiana to be a leader.

We have a rare opportunity. We have a smaller population to deal with. I will pray that it ends in key results to take us to key results. Thank you and God bless you.

Rebecca Seifert, Gennesaret Free Clinic, Director

Gennesaret Free Clinic provides free service to homeless and working poor

Again, thank you all for this opportunity to talk about something I love – health care and our homeless and working poor population we serve in Marion County. Here, 163,000 people have an income between 0-150% FPL. In Center Township, 30% have that same income level. On any given day, 3,500 men, women and children are homeless. Throughout the year, that's 15,000 men, women and children.

Providing health care to this patient population is difficult and daunting. They don't have a fixed address. They may have substance abuse or mental health issues. They may not be educated. They are likely uninsured. They are afflicted by chronic conditions. They often don't have resources to pay for. When they were sick, they were cared for.

Gennesaret comes from the book of Mark. It's a strip of land where Christ healed the sick. We strive to provide comprehensive care to our patient population. (List of services offered by the Clinic.)

How do patients get to us? We use a mobile model of care. We take health services to the people. Our "clinics" are located in shelters and missions in Indy – or a mobile unit outfitted as a doctor's offices. We adjust times and places so that patients can easily access them. They receive medicines too. They have wellness clinics for more diagnostic care; it's more like a primary care doctor's office. One of the clinics I'm proudest of it is our dental clinic, founded in the 80's. Last year, we provided over \$600,000 worth of dental care free of charge. In first quarter, we had 832 dental patients. We receive calls and emails from people all over – even outside Marion County – who want dental care. Please include dental in the health care services that we provide.

We also provide a place for homeless men that have been hospitalized and need a place to live. If you're homeless, how would you like to recuperate at Lighthouse or Wheeler Mission? They are nice places, but they're not conducive to recuperating. Help the individual to heal physically and mentally. Our goal is to discharge them to an apartment, instead of the street. Last year, 85% were discharged to their own apartment and 90% were fully healed from their diagnosis.

The major challenge of providing care to this patient population is to understand the needs of the patients. We must partner with other agencies to effectively use all those resources. The Public, private, non-profit worlds must work together toward a solution.

QUESTION AND ANSWER

Question by Cheryl Parker, Moderator: Massachusetts recently passed a law that mandates health insurance for all people. Would that proposal work in Indiana?

Sec. Roob: The long portion of this presentation available on the web goes into the details. Frankly, they started their process in a much different place. They already offered up to 200% of the Federal Poverty Level (FPL); we're at 22% of poverty. Our situation is more analogous to a situation being pursued in Michigan; they are at 40% FPL. They have similar problems with a loss of manufacturing jobs. We are using Sellers Feinberg – who worked on MA's proposal – to help us develop an Indiana proposal. Another important piece of this discussion is the option for small employers to buy into a product that is negotiated with a larger risk pool; this is an "exchange." MA did pioneer this notion of costs not otherwise matchable (CNOM), which is important to offer an expansion within our fiscal restraints. I find it unlikely that we would go to the level at which MA did – in terms of the personal mandate. I don't think that the relative conservative state of Indiana is ready for that.

Q: The proposal would provide coverage to the uninsured through managed care organizations. Should the new solution limit how much is spent on administration, so that more care can be provided to the uninsured?

Sec. Roob: An organization was formed in Indianapolis in the 90's; this is now MDWise. The hospitals take that risk directly and manage it. We have a Request for Proposal (RFP) that we put out this year to encourage further regionalization of health care for low and moderate income people. No offense to insurance companies, but this option removes the insurance company as an intermediary, which allows the entity to put the cash back into the risk pool. That's the only way we could make risk-based managed care (RBMC) work when I was at Wishard.

Matt: We're doing that now. Even with direct risk taking, we're at a 12% overhead rate.

Q: What will stop the inappropriate use of emergency rooms?

Matt: The people who don't have health insurance go to the ER because they don't have a relationship with a primary care physician, so that they can get that health care in the appropriate venue.

Cheryl: In 2004 in Indiana, 42% of the uninsured adults were not able to see a personal doctor or provider.

Matt: Another disturbing trend is that more doctors are declining to see indigent patients. That heightens the problem of people needing to go to the ER. I don't blame the doctors; the pressures on doctors are enormous. They must be highly productive. Rather, it's a criticism of our entire health care system.

Billie: We need to use education; my employees use the ER because they don't realize how much it costs. People that don't pay for their insurance don't understand the costs.

Q: Are the community health centers being considered as a part of the answer?

Rebecca: Oh, I hope so. They are vital. Raphael Health Center is unaffiliated with a larger hospital entity; that's tough. The health centers serve Medicaid patients and people that cannot afford to pay.

Rev. Walker-Smith: They are particularly important to congregations that are in the neighborhoods to serve as centers, particularly when the hospitals are further way.

Rebecca: Free clinics play a huge role in this as well. Our model of care to homeless people is different than the model of other clinics.

Sec. Roob: Let me make this cautionary point. The cobbled together strategy to provide health care to the low income that exists in Indianapolis today will be substantially altered. The folks at Tabernacle Presbyterian Church who have poured out their money and love and their Christian dedication to those in need, through the development of Raphael.... we will turn that into a monetary transaction. The only way for me to avoid that is for this not to happen. It changes the fabric of the way communities feel about health care. I don't have a solution. We agreed to have a very public conversation.

Cheryl: Please give specific examples.

Sec. Roob: Matthew 25 in Fort Wayne gives away millions of dollars of care; they are a facility that gives away free care to Allen County residents. Almost every person that receives care there would be provided a benefit; they could receive care in a doctor's office. I tell doctors, "You're unhappy about what I pay you in Medicaid. The reimbursement in this new product will not be very much better. You willingly give away millions of dollars." People believe firmly in giving away health care to those that need it. To do this, we will frankly take money away from Marion County to share with others.

If we decide to do something, the cure may be worse than the disease. We have to recognize what that cure looks like. I want to be upfront. I don't want the people whose blood, sweat and tears have been poured into treating these people to say they didn't expect the consequences. That's why we're talking about it now.

Q: Cuts as outlined by the federal government will affect people. They will reduce the number of children in the Children's Health Insurance Program (CHIP). (Specific statistics cited.) How are you preparing for more limited resources?

Sec. Roob: Those numbers are not what we are familiar with. We will not see substantial alterations in the CHIP program in Indiana. We believe we have implemented changes to live within the 5% budget allocated by the Governor, Sen. Miller, and other legislators. We've had to make difficult choices, but we've done it. I don't anticipate reducing the number of people served or cutting the rolls.

Q: Would you consider free market options for the uninsured?

Sec. Roob: For a family of four, health care costs are \$8,000/year. A free market approach would work if you decided to help subsidize a relatively poor person. What would work is allowing a partially subsidized government funding, on a sliding scale, so that employer, employee, and government can pool resources to collectively purchase one of several packages. If we put together a plan, we would look at a health savings account that is partially government funded as one possibility.

Matt: In talking about the free market in the health care system, it's helpful to make a distinction between the health delivery system – hospitals, doctors, therapists, etc. – and the funding of health care. Relying on the free market and purely economic principles are greatly against us.

Q: What's the cost of state-sponsored care for the person who is 250% FPL with two children?

Sec. Roob: I think the risk based managed care would probably be \$400/month range. They could buy into the program. It's still not inexpensive. You can alter the benefits package too; that affects the cost. (Note: At 250% FPL, the family would likely not be subsidized by government; however, they could have better access to health care through an insurance exchange, the concept initially developed by Massachusetts.)

Cheryl: Is it safe to assume that we're moving away from the employer sponsored system?

Matt: Absolutely yes. The U.S. is a complete freak in this area. No other country links health care to employment. It's an accident that it ever happened. In 1942, the national government passed a wage freeze – so then employers decided to offer health insurance to employees as a way to increase their wages. It's resulted in a system that's killing our businesses. No other country does this.

Billie: It's killing small business in this state.

Q: What are the disadvantages of a federal health program?

Matt: Medicare is a federal health program. Consumer polls show that Medicare is their favorite provider. Doctors love Medicare; they pay quickly with limited forms. It's the cheapest to administer. Anthem is the behind-the-scenes administrator of Medicare. Medicare works well for our seniors; I think it would work well for others.

Sec. Roob: It's an interesting question, but it's not possible for us in Indiana. You can debate Matt's point, but at least in the near term, we'll debate this in Indiana. If you want to go to a national system, you can go to folks other than me. It's above my pay grade.

Let's deal with it pragmatically here. People have talked about a national solution for at least two generations and nothing has happened. Do we want to solve it in an Indiana way... or do we want to wait?

Matt: I hope the federal government looks at it as well. I hope we look at a parallel track.

Q: If county care goes away to the state level, what will happen to property taxes?

Sec. Roob: That's a great question. Low income health care in Marion County works much better than anywhere else in the state. No other county has a "Health and Hospital Corporation," as does Marion County. Taxpayers in Marion County spend a lot more in their taxes than other counties to fund this. I doubt we could afford for property taxes to go to zero. The maintenance of effort would be needed.

Q: Under any new Medicaid, will the PPS (prospective payment system) rate?

Sec. Roob: It's a Medicare term.

Matt: Trick question.

Q: What would be the most effective first steps toward the goal of giving all residents access to affordable health care? Is it this discussion here tonight?

Sec. Roob: We experimented with first steps when we created Wishard Advantage. We tried to take a cash flow that was only going to hospitals and give it to patients. HHC can only get so far down that path at the local level; the state level has more leveraging opportunities. I have not conceptualized a gradual process. You have to take the funding from so many different places, so you have to take a big leap.

Matt: I agree completely with Secretary Roob. We have been trying to take incremental improvements over the past 25 years, but none of them have created meaningful reform. It will take a big step. There needs to be a complete collaboration between various communities – business, faith-based, neighborhood leaders, advocates, philanthropic – to come together and say, this is problem that needs to be addressed right now. It must take leadership from our government officials.

Sec. Roob: Physicians will also have to change how they are used in the office. When you graduate from medical school, you have a lot of debt. You are a scientist and you

must make money. That drives career choices. We have to look at the way we deliver care. We should leverage physician extenders, such as nurse practitioners. Throwing more money at the current process won't fix the problem.

Q: So many problems are related to lifestyle choices, such as obesity and smoking. How does a single pool affect that?

Matt: Right now, there's almost no way to pay for preventive and public health, lifestyle choices. You pay over and over again when you go to the doctor's office. It's the only market in the world where you get paid more for the more mistakes you make. I don't blame the doctors for this. Society has chosen not to fund public health efforts.

For example, suburbs are hazardous to your health. Not living near running paths is hazardous to your health.

Dr.: I encourage faith communities to realize their role in health. It's in the holy text. Promote body, mind and spirit – it could really be revolutionary. Those three components of being a person are all there.

Q: Our health care delivery system has significantly invested in infrastructure. The profits realized by these hospitals result in higher costs for all. How will the plan look for those entities that benefit from the current system – and not changing?

Billie: If you look at the cost of the CEOs in the health care system, it affects us all. The cost of health care is prohibitive to employers and employees. We need to educate our people about healthy lifestyle choices. In the last 5 years, hospitals have made more profit than ever before.

Matt: We have more heart hospitals in Indiana than all of Europe, I think. There's an economic reason why we have it. I do not blame the doctors. We have had a system that takes the uninsured, and we have to treat you in the ER. Docs and hospitals give massive amounts of free care. The only way to get around that is to give a specialty care hospital that does not have an ER. It's a natural, free market reaction to our irrational health care system. They have to do that if they don't want to be captured by the system.

Billie: I don't agree with all these building. Five heart hospitals within 30 minutes, while there are only 100 in the whole United States.

Note: There were a few questions that were unable to be addressed at the forum, but that were written down on note cards. These questions will be addressed and posted on the website shortly.